

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5655 STATE FILE NUMBER 2463-040187

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>MIAMI</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>PAOLA</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARY'S HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>ROUTE #1</u>	
Length of stay in lb <u>14 HOURS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>NADYNE</u> Last <u>SUMMERS</u>			4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>18</u> Year <u>1963</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1920</u>	9. AGE (last birthday) <u>43</u>	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (City and state or country) <u>CHEYENNE AGENCY SOUTH DAKOTA</u>	
13a. FATHER'S NAME <u>JESSIE O. POPE</u>		13b. MOTHER'S MAIDEN NAME <u>DOLLY ALICE BENNETT</u>		14. NAME OF HUSBAND OR WIFE <u>PAUL R. SUMMERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u> </u>		
17. INFORMANT <u>PAUL R. SUMMERS, PAOLA, KANSAS</u>			Address <u> </u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrauterine Fetal Death</u> DUE TO (b) <u>Embryonic Hemorrhage</u> DUE TO (c) <u>Embryonic Necrosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	--	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u>	STATE <u> </u>
21. I attended the deceased from <u>10/18/63</u> to <u>10/18/63</u> and last saw her alive on <u>10/18/62</u> Death occurred at <u>7:00 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>H. Underwood, M.D.</u>			22b. ADDRESS <u>5100 E 24th St. KCMO.</u>		22c. DATE SIGNED <u>10/19/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>OCT. 19, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL CEM.</u>		23d. LOCATION (City, town, or county) <u>EXCELSIOR SPRINGS MISSOURI</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS, NORTH K.C. MO.</u>			25. DATE RECD. BY LOCAL REG. <u>10-19-63</u>		26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

H. Underwood

Dr. J. A. Underwood
St. Mary's Hospital

APR 3 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John W. Halsbee

Licensed Embalmer No. 4949

P. O. Address

McDonnell City 16, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.